

STANDARD CERTIFICATE OF DEATH

FILED NOV 1 1957

35716
STATE FILE NUMBER 4726

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION V.A. Hospital		d. STREET ADDRESS 1406 Bellefontaine	
3. NAME OF DECEASED (Type or print) HARLEY J. CAMPBELL		4. DATE OF DEATH 10th 13th 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-7-89
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GUARD		11. BIRTHPLACE (City and state or country) Lindgren, Iowa	
13a. FATHER'S NAME John L. Campbell		14. NAME OF HUSBAND OR WIFE —	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWT		17. INFORMANT V.A. Hospital Records, K.C., Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrhythmia DUE TO (b) Acute myelogenous leukemia DUE TO (c) 2041		INTERVAL BETWEEN ONSET AND DEATH 1 month	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORKING <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from October 8, 1957 to October 13, 1957 Death occurred at 2:30 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE Charles A. Kendall MD	
22b. ADDRESS V.A. Hospital, K.C., Mo.		22c. DATE SIGNED 10-13-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE OCT. 13, 1957	23c. NAME OF CEMETERY OR CREMATORY MT. VERNON CEMETERY	23d. LOCATION (City, town, or county) (State) MELBOURNE IOWA
24. FUNERAL DIRECTOR D.W. NEWCOMER & SONS, KANSAS CITY, MO.		25. DATE RECD. BY LOCAL REG. 10-13-57	
26. REGISTRAR'S SIGNATURE Neva Minshall			



STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by, Student Embalmer No.
working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Chester K Brown*

Licensed Embalmer No. *4931*

P. O. Address *KC MO*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.